(p) **Regional pools in 1986 and 1987: bad debt and charity care.** Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the rate years 1986 and 1987. Such pools shall receive funds from hospitals pursuant to the provisions of this subdivision and section 86-1.37 of this Subpart. For the rates established in 1986 and 1987, the resources available for the purposes of establishing the bad debt and charity care pools shall be calculated on the basis of four and one-half percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient costs after application of the trend factor excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal Social Security Act, and inpatient uncollectible amounts.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (q) of this section, a facility must meet in 1986 and 1987 the criteria specified in paragraphs (1) and (2) of subdivision (g) of this section with the following exception: a policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1987. Compliance with these criteria shall be subject to audit.

(2) For the purpose of this subdivision only, the following words or phrases shall be defined as follows:

(i) **Major public sector** shall mean all State-operated general hospitals, all general hospitals operated by the New

York City Health and Hospitals Corporation as established by chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual inpatient operating costs in excess of $25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) Hospital need shall be calculated pursuant to the provisions of paragraph (3) of subdivision (g) of this section.

(4) reserved

(p)(5) reserved

TN NY 89-6 Approval Date JUL 21 1992
Supersedes TN 88-6 Effective Date JAN 1 - 1989

(p)(6) reserved

(p)(7) reserved

(q) reserved

TN NY 89-6 Approval Date JUL 21 1992
Supersedes TN 88-6 Effective Date JAN 1 - 1989

(r) reserved

(s) a case mix adjustment to general hospitals' rates of payment and revenue caps shall be made in 1984 and 1985 and to general hospitals' rates of payment in 1986 and 1987 according to the provisions of this subdivision.

(1) For 1984 and 1985, a hospital shall have its case mix changes from 1981 to the appropriate rate year calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department, and diagnosis related group (DRGs). (The SIWs are the relative cost weights established by the department for DRGs such that the SIW for any given DRG indicates how expensive the average patient is in those DRGs compared to the average patient in all DRGs). The operating cost per day SIWs shall be all-payor SIWs.

87 5

Attach. 4.19-A
Part I

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(2) For 1986 and 1987, a hospital shall have its case mix changes from the previous rate year to the appropriate rate year calculated on the basis of the non-Medicare patient discharge data sumitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.2 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department and diagnosis related groups (DRGs). The operating cost per day SIWs shall be non-Medicare payor SIWs.

(3) [In 1984 and 1985, hospitals] Hospitals whose case mix as measured according to the provisions of [paragraph] paragraphs (1) and (2) of this subdivision increased by an amount less than or equal to 1 percent but did not decrease by an amount greater than [or equal to] 2 percent shall not receive any adjustment. Hospitals whose case mix increased by more than 1 percent [or more] or decreased by more than 2 percent [or more] shall receive an adjustment to their operating rates of payment and revenue caps pursuant to the provisions of paragraph [(5)] (4) of this subdivision.

[(3) For 1986, a hospital shall have its case mix change from 1985 to 1986 calculated as follows:

(i) The department shall evaluate all hospitals' patient discharge data used as the basis upon which the hospital's case mix change is calculated for the percentage of patient records which, relevant to the data necessary to assign a patient to a diagnosis related group, are either inconsistent, incomplete, or not sufficiently specific.

(ii) A hospital having 10 percent or less of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the Department, and diagnosis related groups. The SIWs that shall be used shall be payor-specific.

(iii) A hospital having more than 10 percent of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights, and patient groupings which shall include major diagnostic categories and may include such factors as:

(a) presence of surgical procedures other than imaging procedures;

(b) sex; and

87-5 superseds 85-34

Approval Date JAN 29 1988
Effective Date JAN 1 1987

87 5

Attach. 4.19-A
Part I

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(c) age,

The SIWs that shall be used shall be payor-specific.

(4) In 1986, hospitals shall have their operating rates adjusted for only those payors whose case mix index calculated according to the provisions of paragraph (3) of this subdivision changes by 1 percent or more. Adjustment shall be made according to the provisions of paragraph (5) of this subdivision.

(5)] (4) The rates of payment and revenue caps of hospitals eligible for a case mix adjustment shall be adjusted as follows:

(i) [in no case shall the first 1 percent of change in case mix be reflected in an adjustment to hospital rates of payment and revenue caps, except as calculated for rate years 1984 and 1985 pursuant to paragraph (2) of this subdivision;

(ii)] for those hospitals receiving an adjustment pursuant to the provisions of paragraph (3) of this subdivision the operating cost per diems paid to hospitals shall be adjusted upward or downward in direct proportion to the percent of change in case mix, as measured according to the provisions of either paragraph (1) or [(3)] (2) of this subdivision, as appropriate, that exceeds [1 percent, except as provided in paragraph (2) of this subdivision] the corridors established in paragraph (3) of this subdivision and in accordance with subparagraph [(iii)]ii of this paragraph; and

[(iii)]ii the commissioner shall not recognize the total upward case mix adjustment provided for in this subdivision if he finds that prior rate year adjustments have previously reimbursed a portion of all of such case mix associated cost increases. Such prior rate year adjustments shall include adjustments pursuant to section 86-1.12 of this Subpart which included an adjustment for case mix and that portion of any rate adjustment made pursuant to paragraphs (1), (3), (4) and/or (7) of section 86-1.17(a) of this Subpart which accounted for a change in case mix.

Approval Date JAN. 29 1988

Effective Date JAN. 1 1987

87-5
supersedes
85-34

OFFICIAL

Attachment 4.19-A*
Part I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW YORK

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INPATIENT HOSPITAL CARE

10 N.Y.C.R.R. PART 86-1

*Mandated Federal Reference

86-1.12* Volume adjustment. Within six months following the rate period, a volume adjustment to the rate will be made for those hospitals which meet the following criteria and which are entitled pursuant to the following calculations:

(a) The adjustment will be available for all hospitals except those:

(1) which closed during the rate year of the volume adjustment; and

(2) with rates calculated based on budget.

(b) The rate will be adjusted according to the following rules:

(1) The change in total certified days will be construed as the net change in total certified days attributable to a change in the facility's average length of stay from the base year to the rate year and a change in the facility's number of discharges from the base year to the rate year.

(2) Any change of less than one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in no rate adjustment.

(3) Any change of less than five percent but greater than or equal to one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in an automatic rate adjustment, from which there shall be no administrative appeal.

(i) In calculating this automatic rate adjustment, it will be recognized that all of a facility's capital costs are fixed. Operating costs shall be considered fixed where there are decreases in volume as measured by discharges and/or average length of stay. Operating costs shall be considered variable where there are increases in volume as measured by discharges and/or average length of stay.

(ii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in average length of stay from the base year to the rate year shall be made incrementally according to the steps in the following table:

| Decrease in Patient Days | | | Increase In Patient Days | | |
|---|---|---|---|---|---|
| (% Change) | Fixed | Variable Percent | (% Change) | Fixed | Variable Percent |
| 0 to 5 | | 80/20 | 0 to 5 | | 80/20 |
| 5+ to 7 | | 75/25 | 5+ to 7 | | 75/25 |
| 7+ to 10 | | 70/30 | 7+ to 10 | | 70/30 |
| 10+ | | 65/35 | 10+ | | 65/35 |

(iii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in discharges from the base year to the rate year shall be made incrementally according to the steps in the following table:

* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.

| Decrease in Patient Discharges (% Change) | Fixed Variable Percent | Increase in Patient Discharges (% Change) | Fixed Variable Percent |
|---|---|---|---|
| 0 to 6 | 60/40 | 0 to 6 | 60/40 |
| 6+ | 50/50 | 6+ | 50/50 |

(4) A change greater than or equal to five percent in total certified days between the base year and the rate year, adjusted for leap years, will result in a further rate adjustment which will be in accordance with subparagraphs (3)(i)-(iii) of this subdivision.

(i) A facility having a change in total certified days of greater than or equal to five percent may ask the commissioner to review the reasons for the change in volume and toe revise the target volume and/or fixed and variable percentage(s). The commissioner shall determine the cause for the change and its relation to the efficient costs of providing patient care services. Based upon this review, the commissioner may adjust the target volume and/or the fixed and variable percentage(s) cited in paragraph (3) of this subdivision upward and/or downward, independent of the facility's request to allow the hospital to be reimbursed for the costs of efficient production of services for the change in volume.

(ii) Facilities having a change in total certified days of greater than or equal to five percent shall have the right to administratively appeal their rate adjustment pursuant to section 86-1.17 of Subpart, within 120 days of receipt of the initial notice of said adjustment.

(c) Similarly, when utilization in the base year or rate year is affected by labor strikes, lockouts, or by the establishment of a certified hospital-based ambulatory surgery service as defined in section 405.2(n) of this Title, a proportionate revision to the target volume will be determined.

(d) All payment adjustments resulting from the application of this provision shall be made within six months following the republication of rate referred to above.

(e) **Volume adjustment for 1986 and 1987.** Within six month following the rate period, a volume adjustment to the rate will be made in accordance with subdivisions (a) through (d) of this section based upon changes in utilization between 1985 as the base year and 1986 as the rate year, and 1986 as the base year and 1987 as the rate year, with the following exceptions:

(1) The volume adjustment shall take into consideration only changes in total certified days for other than beneficiaries of title XVIII of the Federal Social Security Act.

(2) The commissioner may provide for the volume adjustment in the rate year if the facility submits in writing a request for such an adjustment and the facility decertifies at a minimum the equivalent of the number of beds comprising one nursing unit.

(3) If a hospital has experienced a change of greater than five percent in total certified days between 1981 (base year) and 1985

(rate year), and did not meet minimum medical/surgical utilization requirements of section 86-1.9 of this Subpart in 1985, and received a rate adjustment in accordance with this section, 86-1.12, for the 1985 rate year, the commissioner shall adjust such hospital's 1987 rate for changes in certified days from 1986 to 1987 and shall, in calculating such hospital's 1987 per diem inpatient rate, include those imputed medical/surgical days necessary to meet the minimum medical/surgical utilization requirements pursuant to section 86-1.9 unless such hospital submits in writing by December 31, 1987 a request to decertify the beds necessary to meet such minimum medical/surgical utilization requirements. In no event shall the volume adjustment computed in accordance with this paragraph result in a per diem rate greater than the hospital's actual rate year inpatient per diem costs.